

From the Editors

As the bookend to last month's special issue, we have invited SGIM Council members to write personal essays about a topic of their choice. We've rounded out the issue with some of our favorite cartoons that have served as an excellent foil to the thoughtful editorial content that our associate editors have produced month after month. We welcome new *Forum* editor Bob Centor, who will take the helm in August, and wish him every success during his tenure. And we thank you, our faithful readers, for inspiring us to do our best work in bringing you the essential news, bold perspectives, and provocative viewpoints that shape our Society.

—Tina Slee, Malathi Srinivasan, and Rich Kravitz

THE COUNCIL SPEAKS

General Internal Medicine As We Know It

Frederick Brancati, MD, MHS

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I've had the honor of serving as Division Chief at Johns Hopkins for four years. Early on, when colleagues asked me how it was going, I would say, "Great. No criminal or civil litigation, and the team is thriving despite the NIH downturn and reduced compensation for clinical work." (Actually, I still say that.) Then they would ask about the apparently dire prospects facing General Internal Medicine nationally—dropping pay, low morale, and historically low interest among residents in GIM as a career. Back then I would whisper, "I fear that I may preside over the death of General Internal Medicine as we know it." Now I shout, "I am confident that I will have the honor of presiding over the death of GIM as we know it—and I'm looking forward to it."

Why the change in outlook? Lack of sleep? Too much coffee? A lobotomy perhaps? On the contrary: I assure you, I am alert, oriented times three, upright, and well perfused. (I am also normocephalic and atraumatic.) No, four years on the job have taught me that General Internal Medicine as we know it must die and make way for a new GIM. Same mission, different organization. Same spirit, different people. Lower stress, higher quality.

How might GIM look 10 years from now? Here are a few educated guesses. More team oriented. More technologically advanced. More industrialized (i.e. division of labor and appropriate use of capital). More population-oriented. More enjoyable. Better compensated. Better quality and service. We're already seeing some of these trends play out in two areas: the vertiginous rise of Hospitalists and the deep yearning for a real Medical Home.

Consider first the manifold attractions of hospitalist practice to young physicians. Having just completed a residency that is all about hospital practice, they are ready to serve on day one. When they're off duty, they're off. They can plan vacations, dinners, and down-time without fretting about call or coverage—that's already built into the team concept. Their practice is fully capitalized: computers, equipment, nurses, support staff, and trainees all at their command. And they can

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Vertical vs. Horizontally Integrated GIM Research

Said A. Ibrahim, MD, MPH

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As we advance in our academic research careers, most of us are expected to contribute to the development and the nurturing of the next generation of clinician-investigators by becoming mentors. Although there are many and varied mentoring courses and development seminars designed to help mid-level academic investigators become effective mentors, the common reality is that we most often learn how to mentor from our own experiences as mentees. I have certainly attended my share of workshops and mentor training sessions offered at my institution to master the art of mentoring. Yet there are some key discussion points that arise early in the mentor-mentee relationship that remain ambiguous. For example, the decision about whether to focus on a specific disease or to adopt a thematic approach to a budding research career is often left up to the mentee.

In general, I have noted that junior investigators pursuing a generalist research career typically adopt one of two common approaches.

For descriptive purposes, let's call them the vertical approach and the horizontal approach. The vertical approach represents the traditional health sciences research approach where the investigator focuses on one specific clinical content area, such as HIV or depression, and conducts research on numerous dimensions of that condition ranging from epidemiology, diagnosis, management, and outcomes. The horizontal approach is relatively new and, to a large extent, coincides with the proliferation of health services research and generalist research. In the horizontal approach, the investigator adopts a thematic approach to research that does not necessarily focus on one specific disease or medical issue. For example, health care disparity is a thematic content area where one could develop expertise in unique methodological approaches to health disparities and apply that expertise across various clinical conditions. For instance, an investigator may focus on the theme of doctor-patient communication to examine how communication during clinical encounters impacts health care equity.

Obviously, there are advantages and disadvantages to both approaches that I often discuss with my mentees at the beginning of our relationship. Advantages to the vertical approach include conformity with the established health research paradigm where one strives to attain comprehensive expert knowledge about a specific condition or health issue. This approach allows one to easily identify the knowledge frontier, expose gaps in the evidence base, and ask innovative questions that push the field forward. Another key advantage of the vertical

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SGIM: More Than a Meeting

Lisa Rubenstein, MD, MPH

SGIM members embody a critical set of professional skills, talents, and viewpoints that cannot be fully developed or expressed individually and that can be powerful when linked.



At the moment, I am sitting in my home office (beautifully decorated in inspiring hues by my soon-to-be-married daughter), thinking about the upcoming SGIM Council retreat next week. By the time you read this, the retreat will be over, and SGIM will have set the next milestones for its path. You can probably understand my feelings of both trepidation and excitement. Underneath is a strong sense of trust in the collective wisdom of our Council members, each one of whom is not only a leader in his or her own right, but someone who has actively participated in the many facets of our Society from the regional to the national. Together, this group directly represents or is connected to diverse interests and perspectives we value as a Society. You will be reading some brief thoughts from many of them in this issue of *Forum*.

This train of thought leads me to consider why SGIM is so important to so many of us. These Council members could be spending the time they put into SGIM applying for grants, educating the next generation, making nice with their deans, or helping an additional patient instead of nurturing our Society. Granted, participation in SGIM has career benefits, but those benefits can probably be reaped without giving as much. These people, and the many other members who support SGIM in ways to numerous to count, apparently see this organization as adding substantial value to their professional lives.

I am reminded of a conversation I had with an organizational theo-

rist, during which we concluded that the outcome of the 21st century would be substantially determined by the degree to which we learned to be successful in the care and sustenance of our organizations. We have advanced technically to an alternately exciting and frightening degree, but can our social evolution keep up? Our professional organizations, from practices to hospitals to medical schools and national societies, are the means by which each of us is more than ourselves alone and by which we become, as a group, more than the sum of our parts. SGIM members embody a critical set of professional skills, talents, and viewpoints that cannot be fully developed or expressed individually and that can be powerful when linked.

The SGIM Council and core mission committee chairs (research, education, and clinical practice) will meet near Baltimore at the Belmont, an historic manor house built in 1738 and now owned by Howard Community College (and previously by the American Chemical Society). Hopefully, walks in the surrounding forest and delicious meals ("cooking with chemistry" was one of the chemist's slogans!) alternating with the brain pain of trying to foresee the future and how to get there will harness the group's wisdom. I was last at Belmont during an SGIM Innovations Retreat years ago. Among other advances, that retreat led to innovations that recognized and supported clinician-educators as a key SGIM constituency and a focus on the question: "Is SGIM just a meeting?"

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SGIM Forum

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The SGIM *Forum* is a monthly publication of the Society of General Internal Medicine. The mission of The SGIM *Forum* is to inspire, inform and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research and health policy). Unless specifically noted, the views expressed in the *Forum* do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Managing Editor, Co-Editors or Associate Editors with comments, ideas, controversies or potential articles. This news magazine is published by Springer. The SGIM *Forum* template was created by Phuong Nguyen (ptnnguyen@gmail.com).

Walking & Crossing the Line: Taking Advantage of All the Verbs in GIM

Neda Ratanawongsa, MD, MPH

I learned that a proper cover letter should start with the type of job you are seeking, traditionally a clinician-educator (CE) or clinician-investigator (CI) position. I found this decision so daunting that I contemplated a fourth year of fellowship. Even now, after finding a job, I always think twice when checking the CE and CI boxes on SGIM forms.

Since first attending as a resident, I have loved the Annual Meeting for its incredible diversity of people. In my interest area of patient-provider communication, you find outstanding presentations by educational researchers, program administrators, practice administrators, health services researchers, and more. I get winded running from Innovations in Medical Education to Health Disparities to Quality of Care to keep up with all the new data.

Still, I always sensed a divide between educators and investigators—

if not in the abstract sessions then at least in the real world. CEs who face demanding clinical schedules and a dearth of funds can find it challenging to conduct educational research. CIs who face high expectations for publishing and grant support can be discouraged from teaching. Division chiefs strive for ways to balance the books and guide their faculty through promotion. Attempting to cross the imaginary line that divides CEs and CIs can seem daunting to a trainee who naively wonders, “Can I find a job where I do both?”

I am among those who yearn to cross the divide. I want this because—despite the purported downsides of each path—I can’t imagine a more rewarding career than one in GIM.

In my first real job, I feel lucky. I spend part of my time as an assistant program director for a residency with amazing trainees. I

collaborate with educators to design curricula to promote trainee well-being and patient-centered care. My research mentors include educational and health services researchers who each recognize that my teaching and research activities inform and enhance my work with them. Finally, I am enriched by my patients, whose stories touch and refuel my soul. Each part of my work inspires the other, and I can’t choose between them.

My one-on-one SGIM mentor said I didn’t have to choose. I asked for a mentor who would understand my fundamental dilemma: I didn’t know what kind of job to seek. He was a health services researcher who snuck around his institution to teach and design educational research. Instead of telling me ways to negotiate a % FTE, he asked me simply what gets me going each day. Like my fellowship directors, this crazy guy at SGIM told me to forget the labels and stay true to myself.

In the end, the unifying trait of every general internist is that we chose a field that opens rather than closes doors. GIM offers us the opportunity to care for patients young and old, at home and abroad, with a variety of acute and chronic conditions in inpatient, outpatient, home, and community settings. GIM offers us a career characterized by doing important things: learning, teaching, designing, studying, mentoring, writing, advocating, changing, caring, serving, creating, growing. I like all of these facets of GIM, and I’m not giving any of them up.

SGIM

Dr. Ratanawongsa is outgoing Associates’ Representative on Council. To provide comments or feedback about this column, please contact her at neda@jhmi.edu.

Academics and Driving Real-world Change

Marshall H. Chin, MD, MPH

Most of us entered academic medicine because it was a chance to make a difference. However, just as people joke that raising a child is an 18-year experiment before you know the outcome, teaching medical students and residents and building a line of research are often long-term projects.

Over the past three years, I've directed the National Program Office for a Robert Wood Johnson Foundation program called *Finding Answers: Disparities Research for Change* that seeks to discover, evaluate, and disseminate interventions to reduce racial and ethnic disparities in care. Working with RWJF on this project has made me acutely aware of the contrasting time horizons of academia and forces pushing for rapid real-world change.

Recently I've tried to develop new skills to impact real-world change that go beyond our traditional triad of clinical care, teaching, and research. These new activities have kept things fresh and have probably enabled me to do a better job with my core academic responsibilities. They were also surprisingly easy to get involved in. I describe these below so that you might consider giving them a try also.

Communicating with a broader audience through the media. Working with the media can initially feel uncomfortable. I began to get over my awkwardness putting on the media hat when I realized that it was a way to drive change by influencing many people and that we have a responsibility to disseminate our research and model programs as widely as possible. The principles of media training are not complex (e.g. "Stay on message."). University and medical center public relations departments are happy to prepare you for interviews with media and are eager to develop databases of local experts willing to speak to reporters.

Media opportunities include local newsletters, medical trade journals, and general newspapers and magazines. Looking at the health articles in the *Chicago Tribune* newspaper, I'd estimate that one quarter of the time physicians are quoted, they did not need any expertise beyond their general experience as practicing physicians.

Working with community partners. Charlie Parker, perhaps the greatest jazz saxophonist of all time, created a number of legendary records with a string orchestra. The classical musicians were awestruck by Mr. Parker's creative genius and virtuosity as he played his rapid bebop riffs. Similarly, Mr. Parker greatly admired the precision and discipline of his classical colleagues. Analogously, physicians and community-based organizations have complementary skills that can improve our patients' health. I've collaborated with a number of Asian-American community health organizations as well as associations of community health centers. I have been awed by my partners' skills in advocacy and grassroots community mobilization and the ease with which they negotiate political and social waters. How do you get a foot in the door? First, you can volunteer. When I first arrived in Chicago, I spent a year giving a weekly health lecture to older adults at one of the local Asian-American social service agencies. I later participated in a community-based participatory research project involving osteoporosis screening in Chinatown. I eventually got involved in research committee work with community organizations.

Engaging in political advocacy. While I had previously sent emails to my elected representatives, this year was the first time I participated in SGIM's Hill Day, going to Capitol Hill and speaking to the staff of

I have been awed by my partners' skills in advocacy and grassroots community mobilization and the ease with which they negotiate political and social waters.

Senators Barack Obama and Richard Durbin and Congressman Bobby Rush. It was a fantastic experience. Most of the other SGIM Hill Day participants were first-timers like myself. Kavita Patel, Preston Reynolds, Harry Selker, and John Goodson gave us a crash course on the legislative process, Title VII education programs, comparative effectiveness research, and physician reimbursement, and then off we went in teams to see our elected representatives. While the actual time with our representatives' staff was rewarding, I found it equally powerful hearing the message that this was the first step in establishing a long-term relationship with our senators and congressmen to influence policy. I strongly encourage you to participate in a SGIM Hill Day or local "Off-Hill" day to meet your representatives. We all had a great time and felt we were making a difference.

So, working with media, partnering with communities, and engaging in political advocacy are three fun ways to drive real-world change in fresh ways while developing new skills. Give them a try!

SGIM

Dr. Chin is in his third year on SGIM Council. To provide comments or feedback about this column, please contact him at mchin@medicine.bsd.uchicago.edu.

An 81-year-old Male with Prostate Cancer, Left Leg Pain, and Weakness

Michael Langan, MD, and Catherine Lucey, MD

An 81-year-old male with multiple medical problems presented at an acute outpatient clinic visit for a chief complaint of left leg pain and weakness. His symptoms began the week prior when he noticed the acute onset of a burning sensation in the lateral aspect of his left thigh. The pain began to increase in intensity over a seven-day period and was accompanied by progressive weakness in the same leg. Symptoms were originally relieved by over-the-counter naproxen but became so severe that his gait was affected. With the exception of some mild low back pain, his review of systems was otherwise diffusely negative.

His past medical history included coronary artery disease, COPD, peripheral vascular disease, hypertension, dyslipidemia, chronic kidney disease, and recently diagnosed prostate cancer. He had not received any treatment for his prostate cancer, stating that his previous doctor told him that it was a “low-grade cancer.”

Medications included aspirin, atenolol, simvastatin, and bronchodilators. He was allergic to IV contrast. His family history was positive for heart disease and strokes. He had a 50+ pack year smoking history.

Physical examination revealed a normal blood pressure and heart rate. He was in no acute distress but showed obvious discomfort in his left thigh. Heart and lungs were unremarkable with occasional expiratory wheezes. Neurological examination revealed significant weakness of the left quadriceps muscles with limitations in knee extension as well as flexion at the hip. Sensation was grossly intact and reflexes were 1+ throughout. No rashes were present.

Diagnosis and Management

Due to findings of significant weakness in the left leg, the patient was sent for a STAT MRI of the lumbar spine. With his history of untreated prostate cancer and new neurological deficit, original concern was for metastatic disease with compromise of the lumbar cord. MRI results showed no evidence of metastatic disease but revealed a giant 14 cm abdominal aortic aneurysm with active extravasation into a pseudoaneurysm or hematoma overlying the left psoas muscle. The patient was admitted for emergent surgical intervention.

Discussion

The prevalence of abdominal aortic aneurysms (AAAs) is approximately 5% among men age 65 years and older.^{1,2} Major risk factors for development of AAAs include smoking, advanced age, hypertension, hyperlipidemia, and atherosclerosis.² Despite previous belief that atherosclerosis was the underlying cause of AAAs, current literature suggests genetic, environmental, hemodynamic, and immunologic factors all play a significant role in pathogenesis.^{1,2} AAAs are asymptomatic in most individuals and often detected incidentally on physical examination or imaging for other indications.²

Rupture of AAAs is often catastrophic. One trial has suggested an overall 30-day mortality as high as 89% in patients presenting with a ruptured aneurysm.³ Elevated blood pressure, smoking, and aortic diameter are considered risk factors for rupture. The risk for rupture for aneurysms 5.0 to 5.9 cm in diameter is low but begins to increase substantially at 6.0 cm or more. Rupture rates of more than 25% in six months have been reported for AAAs

Despite previous belief that atherosclerosis was the underlying cause of AAAs, current literature suggests genetic, environmental, hemodynamic, and immunologic factors all play a significant role in pathogenesis.

greater than 8 cm.⁴ Some recent retrospective analyses have suggested that the risk of rupture is reduced with angiotensin-converting enzyme inhibitors and statin therapy.¹

Intervention is generally recommended for AAAs that are tender, greater than 5.5 cm in diameter, or growing faster than 1 cm per year.¹ Open surgical repair is an established treatment option, with endovascular repair becoming an increasingly popular option for suitable candidates. However, long-term durability of endovascular repair is yet to be definitively established while the ideal population is still being defined.¹

Screening for AAAs in asymptomatic individuals has been a topic of discussion. Some experts have suggested screening all men age 60 to 85, all women age 60 to 85 with cardiovascular risk factors, and both men and women older than age 50 with a family history of AAAs.^{1,5} The US Preventive Services Task Force currently recommends one-time screening for all men age 65 to 75 who have ever

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Educational Innovation as Part of GME Enhancement in the Department of Veterans Affairs

Barbara K. Chang, MD, MA; Gloria J. Holland, PhD; Karen M. Sanders, MD; and Malcolm Cox, MD, from VA's Office of Academic Affiliations

The Department of Veterans Affairs (VA) Office of Academic Affiliations (OAA) has completed phases 1 and 2 of its planned five-year, 2,000-position expansion of graduate medical education (GME), which began in 2006. Based upon the findings of a federally chartered external commission to review VA's GME programs and the deployment of physician residents in the VA system, VA launched its GME Enhancement Initiative with the following goals:

- To address physician workforce shortages by expanding resident positions in specialties of greatest need to US veterans and the nation;
- To address the uneven geographic distribution of residents to improve access to care; and
- To foster innovative models of education while enhancing VA's leadership role in US GME.

As noted in the recently published 19th Council on General Medical Education Report, "Enhancing Flexibility in Graduate Medical Education," (available at: <http://www.cogme.gov/pubs.htm>) increasing the number of GME resident positions will be insufficient to address the problems that plague the US health care delivery system. The time has come to rethink the structure, content, methodology, and venues in which physician residents are trained.

To that end, VA launched an Educational Innovation RFP as part of the 2007 roll-out of GME Enhancement. Six sites, including four in

general internal medicine, were awarded funding for 21 new permanent positions to begin July 1, 2008. The GIM sites and their corresponding affiliated GIM programs are: Augusta, GA (Medical College of GA); Cleveland, OH (University Hospitals Case Medical Center); Indianapolis, IN (Indiana University School of Medicine); and San Francisco, CA (UCSF). Approved innovations will focus on patient-centered care, patient safety, interdisciplinary care, continuity of care, and greater ambulatory training exposure. Of the VA educational innovation sites, two—Indianapolis and San Francisco—were already participating in the ACGME Internal Medicine RRC Educational Innovations Project (EIP). However, while the ACGME EIP designation allows increased flexibility with respect to accreditation requirements and a longer time between site visits, programs may find that they need additional resident positions in order to optimally implement certain innovations. These additional positions may allow for structural changes in the residency program, while at the same time broadening and enhancing the residents' educational experiences.

In 2008, applicants will be asked to demonstrate how their proposed innovations will transform both medical education and outcomes of care, how the innovations will be amplified throughout the training program, and whether the host VA facility is willing to commit operating resources toward additional program support. In the current cycle, the innovation RFP was opened to all specialties and subspecialties, whereas last year applications were only considered from Internal Medicine, Surgery, and Psychiatry.

Restrictions on the applications for new positions are as follows:

- The program must be sponsored in the name of the academic affiliate.
- The program must have an exemplary ACGME accreditation record—i.e., no more than two cycles in eight years and a current cycle of four to five years, with no adverse actions or major citations.
- Program graduates must have a rolling board pass rate of at least 80%.
- Only accredited training years may apply for funding (i.e., no non-accredited years or positions will be funded).
- Training must be at the VA, with sufficient clinical workload and educational infrastructure to support the training objectives of the program.
- The application must be submitted in the name of the VA facility but with the full support of the sponsoring program and institution.
- The application must outline clear educational and clinical outcome objectives and detail how the success of the program will be evaluated.

Apart from expanding training positions, VA is striving to create a community of practice and to support VA faculty development for approved innovation sites. A preliminary pre-implementation meeting of the 2007 awardees was held. Sites are being asked to approach the implementation of their

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Making *Forum* a True Forum

Robert Centor, MD

Starting with the August issue, *SGIM Forum* will have a new editorial board. As the new editor, I have already had many conversations with a variety of stakeholders and convened an initial new editorial board. We have examined many innovations that Rich Kravitz and Malathi Srinivasan introduced and will continue the modifications that they championed. Our goal is to use *Forum* to explore ideas, showcase SGIM issues, and help our members in a variety of ways.

We will emphasize four major areas in each issue. First, we are introducing editorials and op-eds. We have approached many SGIM committees and Council to solicit ideas and submissions. We have an open submission process for any SGIM member. The editorial board will decide which submitted op-eds to publish and will both solicit and write editorials. If you are interested, I suggest that you send me an email with your idea, as I will know if someone else has already planned to address that idea. If you read an editorial or op-ed and have a different opinion, please submit your idea. We want to encourage healthy debate on issues important to internal medicine.

Let me suggest the following guidelines for those who would like to submit op-eds. We are only inter-

ested in issues that pertain directly to internal medicine. We are not interested in political commentary but are interested in opinions on issues that politicians discuss. I hope this distinction is clear. For example, we do not want an attack on a political party, but we are interested in an op-ed in support of single-payer models or one in support of retainer medicine. We will not publish *ad hominem* attacks. We will not publish important op-eds on issues not directly germane to our field.

Second, we will feature two Morning Report cases in each issue—one from inpatient practice and one from outpatient practice. We will be experimenting with the best way to structure these reports. We are not looking for case reports but rather presentations that make important teaching points. For example, an outpatient might present with difficulty swallowing; the discussion would then focus on the appropriate and cost-effective evaluation. I recently saw a patient with hemoptysis who had pancytopenia. If I were to write this up for Morning Report, the discussion would focus on evaluation of pancytopenia.

Third, we hope to feature one research article authored by an SGIM member in each issue. We will summarize the article and interview the author. We desire nominations (in-

cluding self-nominations) to help us find the most interesting articles. The discussion will include information on how the researcher approached a question and why that question is an important one.

Finally, we hope to have a feature called, "How Do You Do That?". This feature will include a question and several answers, such as how one would run an outpatient morning report.

We are excited about the opportunities for *Forum* and welcome any suggestions for other features that we should add. **SGIM**

Dr. Centor is immediate past president of SGIM and an outgoing Council member. To provide comments or feedback about this column, please contact him at rcentor@uab.edu.

VA RESEARCH BRIEFS

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innovation programs as one would a clinical research project. At the national level, one of OAA's goals is to disseminate ideas from the awardee group to potential future awardees and to catalyze innovation within the broader community.

We encourage GIM program directors, site directors, and members of SGIM to consider developing proposals for application in the 2009 or 2010 cycle of the GME Enhancement initiative. Transformative innovations are sought, meaning those innovations that will not only have a revolutionary impact on the educational experience of residents but also will transform health care delivery. The future of US health care and resident education is at stake.

Can we really afford to continue training residents the way that we did in the last century? **SGIM**

To provide comments or feedback about VA Research Briefs, please contact Geraldine McGlynn at Geraldine.McGlynn@va.gov.

Funding Opportunities Showcase

Compiled in April 2008 by Sunil Kripalani, MD, MSc, and Raquel Charles, MD

Agency	Proposal Name	Content	Max. Amount	Due	URL or Contact
Federal Grants					
NIH (NIDA, NIMH)	Prescription Drug Misuse (R01, R03, R21)	Research to identify the extent and determinants of prescription drug misuse	Varies	R01: 10/05/08, 2/05/09, 6/05/09 R03/R21: 10/16/08, 2/16/09, 6/16/09	http://grants.nih.gov/grants/guide/pa-files/PA-08-127.html (also PA-08-128 and PA-08-129)
NIH (various)	Transdisciplinary Research on Fatigue and Fatigability in Aging (R01, R21)	Assessment of and potential interventions for increased fatigue or fatigability in older persons	Varies	R01: 10/05/08, 2/05/09, 6/05/09 R21: 10/16/08, 2/16/09, 6/16/09	http://grants.nih.gov/grants/guide/pa-files/PA-08-161.html (also PA-08-162)
NIH (NIDDK, NIMH)	Adverse Metabolic Side Effects of Second Generation Psychotropic Medications Leading to Obesity and Increased Diabetes Risk (R01)	To examine the adverse metabolic effects of psychotropic medications	Varies	10/22/2008, 6/22/2009	http://grants.nih.gov/grants/guide/pa-files/PA-08-160.html
Non-Federal Grants					
Charles E. Culpeper Scholarships in Medical Science		Career development award	\$108,000/yr x 3yrs	8/15/08 (anticipated)	http://www.4cures.org/sitecontent/How-to-apply-SA/
Society of Critical Care Medicine (SCCM)—Vision Grant		Improving ICU care	Up to \$50,000	9/1/08	http://www.sccm.org/Membership/Grants/Pages/VisionGrant.aspx
American Philosophical Society (APS)—Daland Fellowships in Clinical Investigation		Patient-oriented research	\$50,000/yr x 2yrs	9/1/08	http://www.amphilsoc.org/grants/daland.htm
Prevent Cancer Foundation		Cancer prevention	\$40,000/yr x 2yrs	9/14/08	http://www.preventcancer.org/research2c.aspx?id=36

Why I Am an Academic General Internist: A Letter to My Children

Richard Kravitz, MD, MSPH

Dear David, Aaron, and Joshua,

I will start this letter with an apology. I wish my work were easier to explain. Kids with fathers and mothers who are lawyers or engineers, firefighters or police, store managers or accountants don't have to shrug and shuffle when their friends ask what their parents do for a living.

I am an academic general internist. Most people don't know what that is. Over the years, I've developed a formulaic answer that works pretty well. "I teach and do research at the medical center." In the beginning, I was always prepared to describe some of the projects I was working on, the students I mentored, the patients I saw. It turns out that sort of preparation wasn't necessary. Most people aren't interested. Though you are miraculous children, gifted and talented, spirited and loving and preternaturally wise, it's a fair bet, seasoned by experience, that in this one specific regard, you aren't so different from most people.

Still, I think it's important that you have a better sense of what I do at work and why I do it. I promise to keep it brief.

I am a general internist, a specialist in adult medicine. When I was a boy one of my favorite books was called *The Medical Detectives*. I loved reading about doctors who solved complex problems through a combination of careful observation and critical thinking. I wondered if maybe I could do that. There was no particular cause for optimism. My grandfather spoke little English and worked as a fruit peddler on the streets of Cleveland. My father had a long career in retail sales. Our family valued education, but there was no precedent for going to medical school. I attended a string of mediocre public schools where expectations were modest. I studied

hard, was inspired by a few great teachers, got some breaks, and ended up with a medical degree. Fast forward 25 years, and here I am, a professor of medicine at a great public university, caring for patients, teaching, doing research, and interacting almost daily with some amazingly smart, dedicated colleagues.

As a general internist, my job is to take care of the whole patient. Other specialists focus on the heart, the GI tract, the eye or the skin, or they may emphasize procedures like surgery or endoscopy. General internists question, talk, examine, diagnose, and treat. We see patients when they have vague symptoms that have not yet declared themselves, and we help patients who are coping with multiple chronic diseases. Our field is critical to the health care system as a whole, yet it is under siege. When I was a medical student, it was not uncommon to hear classmates say, "I like internal medicine, but I'm not sure I'm smart enough." Now top-tier graduates are more likely to choose specialties like radiology, anesthesiology, dermatology, and orthopedics—fields that demand less and pay more. I see their point; it can be frustrating to work in a system that seemingly devalues comprehensive, continuous care of patients with complex medical and social problems. Where under-insured patients sometimes have to decide between medicine and food. Where you have to send in the referral paperwork two, three times before the patient gets an appointment. Still, I'm happy with my choice. Part of the reason is the sheer variety. During a single clinic day I might puzzle over a patient with an unusual facial droop, inject some anesthetic into a trigger point, motivate a former athlete to start exercising again, and counsel a woman struggling to adjust to widowhood after the death of her hus-

When I was a medical student, it was not uncommon to hear classmates say, "I like internal medicine, but I'm not sure I'm smart enough." Now top-tier graduates are more likely to choose... fields that demand less and pay more.

band. And then there are the stories: the World War II veteran who survived the Battle of Midway; the Holocaust survivor who made tea for her cats; the immigrant couple who had nothing—except for 55 years of unwavering devotion to each other. Elie Wiesel said God created man because He loves stories. Internists like stories, too, and I find that the older I get, the more I like them.

The "academic" part of being an academic general internist means that I work at a medical school where I teach and do research. Good clinical teaching (that's the kind that takes place around patients, rather than in a classroom) is a lot like good parenting: it takes a lot of preparation, flexibility, and patience, but the rewards are immense. Most of my research is about helping doctors and patients communicate better. Our work has shown that patients frequently have very specific ideas about what might be wrong and what to do about it. Too often, patients are reluctant to speak up, leaving the doctor to guess at their concerns—and maybe gloss over them. Like almost every relationship

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GENERAL INTERNAL MEDICINE AS WE KNOW IT

continued from page 1

focus and work efficiently. Why? Division of labor, of course: divide up the job, and let everyone do what they do best. I'll even stick my neck out and credit Hospitalists with being "population-oriented." OK, not about the community per se, but about the "community" of hospitalized patients. Hospitalists often have access to much better data on their own "population" than do their counterparts in the clinic. Oh, and the salary. Did I mention the salary? A tight labor market is driving compensation up steeply, even at the great academic centers. It's all here. For Hospitalists, the future is now.

Consider next the notion of the Advanced Medical Home. It's a place where patients, staff, and physicians feel comfortable and work together. How? Better use and application of information, including investment in electronic infrastructure. Leaning forward into problems and cutting them off, rather than leaning back and waiting to react. Paying attention to the patient expe-

rience and promoting communication through multiple channels. Staffing up so each team member maximizes quality and efficiency by focusing on what they do best. Getting hand offs right, especially following hospital discharge. Tracking patients and developing population-oriented systems to improve routine care. It could even involve more "off site" medicine—telephone medicine, emails, and remote control of nurse practitioners. It will almost certainly involve channeling individual talent into team accomplishment—think the Preservation Hall Jazz Band. If we get this right, it could be like what FDR did to the US economy in the 1930s or what Joan Rivers' cosmetic surgeon did to her face in the 1990s: perform radical surgery to preserve what was best about the past while adapting to the present.

Who will get GIM through surgery? I know one group already on the case: the Association of Chiefs of General Internal Medicine

or ACGIM. When I joined the ACGIM in 2002, it felt so substantial that I figured it had been established by an Act of Congress during the Lincoln administration. It turns out to have been the brainchild of a handful of visionaries in 1999 who thought the chiefs could help support each other with information and advice if they banded together. They were 100% right. This year, I have the honor of serving as president. I pledge to use the office to help chiefs and their charges work together to hasten the death of GIM as we know it and plan for a better future for our communities, our patients, our students, our families, and ourselves.

And in case you were worried that I sound a little manic, I also pledge to get more sleep and cut back on the espresso.

SGIM

Dr. Brancati is ACGIM president and an Ex Officio Council member. To provide comments or feedback about this column, please contact him at fbrancat@jhmi.edu.

ENDGAME

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in life, the doctor-patient relationship depends on respectful negotiation. The research part of my job is about bringing clarity to these important conversations, helping patients and doctors understand one another.

In his book *Let Your Life Speak*, the educator Parker Palmer advises readers to reflect on past experience when making critical career decisions. What were you doing when you felt like you were in high gear, energized, drawing on your best and truest self? These associations are, just possibly, clues to the real you. What were my clues? I am constitutionally shy but drawn to performance: reading the news for my college radio station, acting in college musicals. What better way to perform in a controlled fashion than as a teacher? In many ways a con-

ventional type, I love to challenge the conventional wisdom. So when we published results showing that drug ads on TV had both benefits *and* harms, I managed to annoy people on both sides of the fight. For a contrarian, it doesn't get much better than that! Besides, I like to write (or at least to have written). Working as a health policy researcher lets me indulge these passions. Somehow, with the help of some pretty awesome mentors, I found my niche.

"You've got to be kidding," I can hear you say. Yes, you've heard me gripe about my work. Maybe it was a new federal reporting requirement, perhaps a colleague who renegeed on a commitment, a grant that went unfunded, or a university administrator taking liberties with the truth. All I can say is, no job is

perfect. There've been times I've felt off balance, when the demands of my work as a doctor, teacher, and researcher have pushed me to the brink. Most of the time, however, I feel privileged to do what I do. Whatever *you* do when you grow up (and you are all growing up faster than I could have ever imagined), I hope that you find work that fits who you are as well as academic general internal medicine fits me.

*Love,
Dad*

SGIM

Dr. Kravitz is editor, SGIM Forum, and an outgoing Ex Officio Council member. To provide comments or feedback about this column, please contact him at rkravitz@ucdavis.edu.

We've had a lot of fun, thanks, from . . .

Rich



Malathi



Tina



VERTICAL VS. HORIZONTALLY INTEGRATED GIM RESEARCH

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approach is that it is, to some extent, aligned with the organization of the various agencies of the National Institutes of Health, the nation's leading funding agency. The major disadvantage of this approach is the narrowness of the focus of research, which may not nurture the career satisfaction of a generalist.

Alternatively, the horizontal (thematic) approach is gaining acceptance as being highly conducive to health services research, while also providing enhanced flexibility to apply

advanced methodological expertise to study a variety of otherwise unrelated medical conditions and/or aspects of health care. That said, this approach has the potential to lead investigators to seek specialization in areas that could conflict with the desire to remain a generalist. For instance, one of my potential mentees once remarked, "Well, if I wanted to be the world's expert in HIV, I would have pursued subspecialty training in HIV and infectious diseases."

So how do you advise a junior in-

vestigator who is considering which approach to adopt? Well, it depends on the training and educational background of the mentee, as well as the reasons he or she wants to pursue a career in generalist research. But when all is said and done, it is important to note that after all it is the "success" that matters more the approach. **SGIM**

Dr. Ibrahim is starting his second year of service on SGIM Council. He may be reached at Said.Ibrahim2@va.gov.

MORNING REPORT

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smoked.⁶ Upon detection, surveillance is essential, and vascular surgery referral should be considered.²

The patient in this case was deemed a suitable candidate for endovascular repair. He underwent successful intervention with an uneventful hospital course. His presenting symptoms were completely resolved within three days post procedure.

Summary

- Major risk factors for development of AAAs include smoking, advanced age, hypertension, hyperlipidemia, and atherosclerosis.
- Intervention is generally recommended for AAA's that are tender, greater than 5.5 cm in diameter, or growing faster than 1 cm per year.

- Given the risk of catastrophic complications, screening for AAAs should be considered for suitable populations.
- The diagnosis of AAAs should be entertained as a cause of low back pain with associated neurologic deficits of acute or subacute duration.

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6. The Guide to Clinical Preventive Services 2007. Recommendations of the US Preventive Services Task Force, September 2007. **SGIM**

To provide comments or feedback about Morning Report, please contact Catherine Lucey at Catherine.Lucey@osumc.edu.

PRESIDENT'S COLUMN

continued from page 3

We directed attention to nurturing ongoing activities of interest groups and now support more than 60 of them (plus five task forces that grew from them). These groups in turn link us to the activities of a broad array of relevant national and international organizations (see the SGIM website, www.SGIM.org). While no single retreat or Council group is responsible for such developments, each one is a part of determining the

patterns that will follow.

There is no other organization, at least in the United States, whose core mission is to support both the academic and clinical lives of general internists—a group whose training and values are of special worth in promoting the health of the public, including the disadvantaged and the vulnerable. In these challenging times, the Council will aim to guide and nourish SGIM as the organiza-

tion that enables our members to bring their very special skills and ethos to the public—through clinical practice, education, and research.

Stay tuned for updates, and as always, send us your thoughts, questions, and ideas. **SGIM**

To provide comments or feedback about President's Column, please contact Lisa Rubenstein at Rubenstein.Lisa@gmail.com.

Positions Available and Announcements are \$50 per 50 words for SGIM members and \$100 per 50 words for nonmembers. These fees cover one month's appearance in the Forum and appearance on the SGIM Web-site at <http://www.sgim.org>. Send your ad, along with the name of the SGIM member sponsor, to ForumAds@sgim.org. It is assumed that all ads are placed by equal opportunity employers.

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Brigham and Women's Hospital's Division of General Internal Medicine and Primary Care seeks an individual to serve as Primary Care Director. The Director oversees all clinical and business aspects of the primary care practices affiliated with BWH, and collaborates with the Division Chief of General Medicine on academic and research aspects of primary care. Academic rank and salary will be commensurate with qualifications. Review of applications will begin immediately.

Send letter of interest and CV to

David Bates, MD,
Division of General Internal Medicine,
BC3-2M, Brigham and Women's
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1620 Tremont St, Boston, MA, 02120.

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ACADEMIC GENERAL INTERNIST

University of South Carolina School of Medicine. Recruiting clinician/educator at Assistant/Associate Professor level to direct internal medicine residents' outpatient continuity clinic. Position entails primarily teaching, patient care, and administration in outpatient setting, but other clinical and academic activities are available, depending on applicant's interest. The medical school is located in Columbia, state capital and home of university's main campus. EOE/AA.

Send CV plus letter expressing reasons for interest in the position to

Allan Brett, MD, Director, General Internal Medicine, Two Medical Park, Suite 502, Columbia, SC 29203; Telephone: 803-540-1000; abrett@sc.edu

CLINICIAN EDUCATOR Division Of General Internal Medicine Department Of Medicine University Of California, San Francisco

The Department of Medicine at the University of California, San Francisco is recruiting for Clinician Educators in the Division of General Internal Medicine who will combine the provision of adult general medical care with other academic responsibilities. Candidates with experience and career interest in quality improvement, adult urgent care, practice innovation, and medical education are encouraged to apply.

Candidates must have a demonstrated skill in general internal medicine, and the provision of comprehensive care to diverse populations, and participated in scholarly activities related to education of medical students or medical residents, collaborative clinical research studies, or other academic activities. Candidates should be American Board of Internal Medicine certified. Please send a cover letter and CV to:

Mitchell D. Feldman, MD, MPhil
Professor of Medicine

Director of Faculty Mentoring
Division of General Internal Medicine
University of California, San Francisco
Department of Medicine
400 Parnassus Ave., Suite A-405
San Francisco, CA 94143-0320

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The University of Kentucky, Department of Internal Medicine is seeking excellent candidates in Internal Medicine for opportunities in academically oriented ambulatory positions in the Division of General Internal Medicine University faculty practices. Physicians recruited will have full clinical faculty appointments, competitive compensation and benefits and the advantages of practice in our academic multidisciplinary group. Candidates must be board eligible or board certified in internal medicine. Our department benefits from an integral association with a vibrant and robust healthcare enterprise, UK HealthCare, which has recently embarked on an aggressive building program that will bring state-of-the-art facilities and technology to our campus as we move toward our goal of becoming a top 20 medical center. The University of Kentucky, founded in 1865 as a land-grant institution, has grown from 190 students and 10 professors to a campus that now covers more than 716 acres and is home to over 26,000 students and nearly 11,000 employees. Recently ranked as one of the safest, most creative, and brainiest cities in the nation, Lexington, KY is an ideal location to experience the work—life balance that the University strives to provide to its employees. Salary will be commensurate with the applicants qualifications and professional experience. Applicants should submit curriculum vitae to:

T. Shawn Caudill, M.D.,
Department of Internal Medicine,
University of Kentucky,
740 S. Limestone, Room K512,
Lexington, KY 40536_0284.

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GENERAL INTERNAL MEDICINE **Assistant/Associate Professor of Clinical Internal Medicine**

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Requirements include: Graduate from an accredited medical school with formal training in general internal medicine; Diplomate of the American Board of Internal Medicine or eligibility required; Eligible for Illinois Medical license. Send curriculum vitae and three references to: **Traci Pezall, SIU School of Medicine, P.O. Box 19636, Springfield, IL 62794-9636.**

Applications will be accepted until the position is filled.

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The logo for the Society of General Internal Medicine (SGIM) Forum. It features the acronym "SGIM" in a white, italicized, serif font inside a dark blue rectangular box. Below this box, the word "FORUM" is written in a large, bold, black, sans-serif font. A thin horizontal line is positioned directly beneath the word "FORUM".

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